LAKE COUNTY
FLORIDA
P.O. BOX 7800 • 315 W. MAIN ST.
TAVARES, FLORIDA 32778-7800

Board of County Commissioners
Office of Employee Services

Individual Authorization for Use/Disclosure of Protected Health Information (PHI)

(Please attach copies only. Do not attach original documents.)

Name of Employee/Retiree: _____

Name of Member: _____ Date of Birth: _____

Relationship of Member to Employee/Retiree: _____

Home Address of Employee/Retiree: _____

Home Phone Number: _____ Work Phone Number _____

Work Location: _____

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by the federal privacy regulations.

1. Person(s) or organization authorized to disclose the health information:
   Employee Services Benefits Representative(s), and _____
2. Person(s) or organization authorized to receive the health information:
   Employee Services Benefits Representative, WEB-TPA and/or other vendor(s)associated with Lake County's Health/Benefit Plan(s),and _____
3. Description of health information that may be used/disclosed:
   Basic information regarding issue at hand, and _____
4. Purpose for which the health information will be used/disclosed, for example assistance in resolving a claim, billing or eligibility issue. *(Note: This is not required if disclosure if requested by the individual)*:

   _____

   _____
5. I understand that:
   - I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits*. ***(Note:** Not required if disclosure is requested by the individual.)*
   - I may revoke this authorization at any time by providing written notice to the Benefits Manager, Office of Employee Services, Lake County BCC, 315 West Main St., P.O. Box 7800, Tavares, Florida 32778
   - My revocation will not affect any actions already taken in reliance on this authorization.
   - I may inspect or copy any information to be used or disclosed under this authorization.
6. Unless otherwise revoked in writing, this authorization will expire _____ (**insert number of days)** days from the date signed below OR upon the occurrence of _____ **(insert name of event, e.g., issue resolved).**

Print Individual's Name	Signature	Date

Print Name of Legal Representative (if applicable)	Relationship to Individual

Disposition of Protected Health Information:

☐ Shredded OR ☐ Returned to Employee/Retiree, though ☐ US Mail or ☐ Inter-office Mail

By Office of Employee Services - employee's name: _____ Date: _____

* A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes. [45 CFR §164.508(b)(4)(ii)(A&B)]

Note: HIPAA "covered entities" (e.g., health plans) must provide a copy of the signed authorization to the individual.